**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team P**

**Name: Antoinette Archer**

**Hospital Day: 77**

Antoinette Archer is a 70 y.o. female peripheral arterial disease, ESRD and failure to thrive who has had a prolonged hospitalization since Sep 2019 (initially admitted with acute encephalopathy), subsequently found to have osteomyelitis and has had recurrent sepsis and C. Diff infection, now w/ klebsiella bacteremia. She no longer is offered HD, and has a poor prognosis, while family is deciding on hospice.

**SUBJECTIVE**

Sleeping

NAEO

No family at bedside

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | CeFAZolin ( ANCEF) IVPB in Dextrose - Standard | 1 g | Intravenous | Q24H |
| • | epoetin Alfa-epbx | 4,000 Units | Subcutaneous | Once per day on Tue Thu Sat |
| • | lidocaine | 2 patch | Transdermal | Q24H |
| • | heparin | 5,000 Units | Subcutaneous | Q12H SCH |
| • | collagenase |  | Topical | Daily |
| • | thiamine | 100 mg | Oral | Daily |
| • | normal saline | 10 mL | Intravenous | EVERY 8 HOURS |
| • | acetaminophen | 650 mg | PEG Tube | Q6H |

**OBJECTIVE**

BP 141/79 | Pulse 100 | Temp 36.6 °C (97.9 °F) (Axillary) | Resp 20 | Ht 1.6 m (5' 3") | Wt 49.5 kg (109 lb 2 oz) | LMP (LMP Unknown) | SpO2 94% | BMI 19.33 kg/m²

GEN: laying in bed, not in extremis

CV: thin exp, tachycardic

PULM: increased WOB, shallow resp

ABD: soft, PEG in place

PSYCH: unable to assess, pt lethargic

All labs, studies, and imaging was personally reviewed.

Cr 1.9

Hb ~7

**ASSESSMENT and PLAN**

 #. Dispo

-Filled out FMLA paperwork for daughter, Tania Archer on 12/11/19

-Re-consulted Palliative Care, Appreciate assistance

-Ongoing Hospice discussions, no definitive decisions made at this time

-No longer offering dialysis (not tolerating, risk v benefit)

#. Sepsis 2/2 Klebsiella bacteremia

-BCx2 (12/2) with ngtd, BCx2 (12/5) growing Klebsiella (resistant only to ampicillin)

-CXR (12/2) without focal consolidation, CXR from 12/5 and repeat from 12/8 showing L sided pleural effusion

-s/p cefepime 12/5-9, s/p ceftriaxone (12/9-12/10). Cefazolin 12/11-p (end date 12/19)

#. L pleural effusion (stable)

- Consider thoracentesis if develops hypoxia

#. Hypoglycemia (resolved)

#. Hyponatremia (stable)

- Receiving TFs

- FWF now 20 mg every 2 hour, will continue to monitor but anticipate this improving with modifcation of FMF and continued TFs

#. Severe *C. difficile* infection

-Positive toxin (11/23)

-s/p PO vancomycin 125 mg QID (11/23/2019-12/7/2019)--> will continue to monitor for s/s of recurrent Cdiff infection

#. Subacute/chronic osteomyelitis of R ankle, suspected/possible RLE SSTI

Frequent episodes of sepsis prior to admission with R 1st toe amputation (9/2019). Imaging on admission was concerning for residual osteomyelitis despite previously completing 6 week course of IV antibiotics (@ S. Regional). On admission, resumed broad spectrum abx but after discussion with ID they were discontinued-- s/p vanc/zosyn (9/28-10/14). Unable to obtain repeat MRI given patient's contractures. Code sepsis in early Nov 2019 with repeaat ID consult. Patient now s/p 2 weeks of IV vanc for possible soft tissue infection of R ankle (11/13-11/27). During this hospitalization, re-discussed with vascular surgery multiple times regarding amputation and therefore source control. At this time, no plans for surgery which was confirmed with family

#. Acute on chronic encephalopathy, c/b vascular dementia

Likely multifactorial, acute worsening related to toxic metabolic from sepsis as below with superimposed delirium; with underlying vascular dementia and slow decline over last several months.  CT with severe chronic microvascular changes but no acute abnormality. HIV negative, TSH nl, RPR negative

-Continue thiamine repletion via PEG

-Overall prognosis is very poor, s/p palliative care consult early during hospital stay with multiple prior family meetings and ongoing GOC discussions. Family has opted against hospice at this point because of not wanting to stop HD or TFs. Palliative care no longer following

#. Chronic multifactorial anemia

#. BRBPR, intermittent

-Suspect multifactorial due to ACD and ESRD with recent GIB. Episode of rectal bleeding witnessed 10/3 and 10/7, CT bleeding protocol negative.  +hemorrhoids on exam.  Suspect hematochezia related to hemorrhoids, Hgb ~ 7.5 and pt is poor candidate for EGD/colonoscopy given overall clinical status and prognosis. S/p transfusions on 9/29,10/10,11/6, and 11/22 with appropriate response. Continue to hold ASA, H/H has remained stable

*Chronic medical problems*

#. Chronic dysphagia- NPO. tube feeds at 40 mL/hr with 20 mL q 2 of FWF

#. Failure to Thrive- no acute interventions

#. End stage renal disease- No longer a candidate for iHD, last session on 12/11

#. Hx of osteomyelitis s/p right hallux amputation

Fluids None Replete lytes PRN.

Diet: NPO, TFs

Lines and Catheters: PIV

VTE Prophylaxis: Heparin q 12

Advanced Directives: Full

Family Contact:  Primary Emergency Contact: Archer,Jackie, Home Phone: 678-763-9311 Tania 704-560-8158

Discharge Planning: Ongoing hospice discussions, end of life care given no longer undergoing dialysis

Dispo/Code status. DNR/DNI.

Anish Shah

Emory Team P

PIC 51380

Hospital Medicine Attending

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team Q**

**Name: Robert Cobbs**

**Hospital Day: 30**

Robert Cobbs is a 38 y.o. male h/o Fournier's gangrene in 7/2018, homelessness who presents with L leg pain x 1 day as well as melena x3 days, found to have Hb 4.3 and sepsis 2/2 L leg abscesses. EGD showed non-bleeding gastric AVMs and large internal hemorrhoids per C-scope. Pt was also noted to have pancytopenia, B sxs (fever and night sweats) and abd LAD and splenomegaly concerning for malignancy likely lymphoma/ leukemia. Pt is s/p BM bx on 11/27 with results so far non diagnostic. TB/fungal etiology also in ddx given cavitary lung lesion. S/p core bx by IR of abd LN- results pending. Currently waiting on diagnostic testing results, and finishing inpatient VAN for MRSA bacteremia.

**SUBJECTIVE**

Feels similar today

Receiving his ABX

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | calcitonin | 4 Units/kg | INTRAMUSCULAR | Q12H |
| • | sennosides | 17.2 mg | Oral | BID |
| • | polyethylene glycol | 17 g | Oral | Daily |
| • | calcitonin | 4 Units/kg | INTRAMUSCULAR | Q12H |
| • | vancomycin | 1,250 mg | Intravenous | Q24H |
| • | ciprofloxacin | 500 mg | Oral | Q12H SCH |
| • | fluconazole | 200 mg | Oral | Daily |
| • | acyclovir | 400 mg | Oral | Q12H SCH |
| • | esomeprazole | 40 mg | Oral | Q12H SCH |

**OBJECTIVE**

BP 109/54 | Pulse 110 | Temp 36.7 °C (98.1 °F) (Oral) | Resp 18 | Ht 1.88 m (6' 2") | Wt 86.2 kg (190 lb) | SpO2 99% | BMI 24.39 kg/m²

GEN: no acute distress, laying in bed

CV: tachycardiac, warm ext

PULM: easy WOB

ABD: soft, nontender, PCN in place

PSYCH: mood/affect congruent, cooperative

All labs, studies, and imaging was personally reviewed.

Labs not drawn last night

**ASSESSMENT and PLAN**

#. Diffuse abdominal lymphadenopathy / splenomegaly s/p LN bx (12/5, pending)

#. Pancytopenia s/p BMB (11/27, nondiagnostic)

- BM bx (11/27) = Blood with atypical lymphocytes and pancytopenia. Mildly hypercellular marrow with patchy involvement by T-cell lymphoproliferative disorder. +CD3, +CD5, negative for CD20, CD10, CD34, TDT, negative for MYC rearrangement and IGH-BCL2 fusion

- unclear if this is an infectious process versus underlying malignancy

- monitoring for infection, fungal w/u pending (Brucella, bartonella, coxiella, cocci, blasto, histo negative)

- viral w/u thus far: RPR, HIV, HCV, HBV negative (HbsAg pos though, and HSV PCR positive)

- cx from LN pending

- sig cipro/acyclovir/fluconazole for neutropenia (12/2 - p)

- PTZ (11/14-11/15), MTZ (11/15-11/17), CPE (11/15 - 11/16)

#. RUL cavitary lesion s/p TB r/o (12/6 AFB smear neg), dx CT chest c- apical lesion

- monitoring in context of above syndrome

- ID on board

#. Melena d/t AVM s/p pRBC x7 (latest 12/9), dx via EGD and negative colonoscopy

#. Anemia of chronic disease c/b poor reticulocyte response

- monitoring H&H, transfuse > 7

- s/p 3 units 11/15, 2 units 11/16, 1 unit 11/29, 12/4, 12/10, 12/12, 12/13

- PPI

#. MRSA bactermia d/t LLE abscesses s/p I&D

- BG ngtd, pt c- inpatient abx (not candidate for OPAT), VAN 11/15 - 12/13

- TTE/TEE negative

- septic arthritis r/o c- dry tap of left ankle by ortho, and surgery doesn't feel lesion above ankle is abscess (rather hematoma)

#. AKI / CKD s/p PCN (11/29) d/t obstructing R ureteral stone

- monitor Cr, stable

#. Transaminitis c- elevated alkaline phosphatase

- pending results of LN bx, GI aware

- viral and hepatitis panel thus far negative (HSV was postiive)

- MRCP c- hepatosplenomegaly c- heterogenous enhancement

#. Multifactorial hypercalcemia (w/u PTH < 1.2, vitD low, SPEP/Kappa/lambda WNL)

- treating c- IV bisphosphonates and IVF (zoledronate dosed 12/10)

- calcium repeaked 12/14, started on 48 hr of calcitonin, redose zoledronate in 1-2 days

- sig IVF @ 200 crystalloid

#. Hypomagnesemia

-Replacing

#. Hypoalbuminemia

-nutrition consult

#. Homelessness

- Appreciate SW assistance.

RESOLVED

#. AKI

#. Melena

Diet: regular

DVT: SCD

Lines: PIV

Code: Full

Dispo: pending w/u and abx

Anish Shah

Emory Team Q

PIC 71350

Hospital Medicine Attending

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team P**

**Name: Arthur Straw**

**Hospital Day: 14**

Arthur Straw is a 67 y.o. male presents with polyarthralgias and found to have a new diagnosis of diffuse scleroderma.

**SUBJECTIVE**

Doing well this AM

Believes his prior auth was completed

Has no one at home tonight for DC

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | mycophenolate mofetil | 500 mg | Oral | BID |
| • | polyethylene glycol | 17 g | Oral | Daily |
| • | docusate sodium | 100 mg | Oral | BID |
| • | cetirizine | 10 mg | Oral | Daily |
| • | acetaminophen | 1,000 mg | Oral | Q8H |
| • | diclofenac | 2 g | Topical | 4x Daily |
| • | multivitamin | 1 tablet | Oral | Daily |
| • | ferrous sulfate | 325 mg | Oral | Daily with breakfast |
| • | TDF-tenofovir | 300 mg | Oral | Daily |
| • | predniSONE | 5 mg | Oral | BID |
| • | Enoxaprin SC inj for VTE Prophylaxis (HIGH risk for VTE) | 40 mg | Subcutaneous | Q24H |
| • | esomeprazole | 40 mg | Oral | every morning before breakfast |

**OBJECTIVE**

BP 103/65 | Pulse 66 | Temp 36.7 °C (98.1 °F) (Oral) | Resp 18 | Ht 1.676 m (5' 6") | Wt 68.7 kg (151 lb 6.4 oz) | SpO2 100% | BMI 24.44 kg/m²

GEN: NAD, laying in bed comfortably

CV: warm ext, NRRR

PULM: easy WOB

ABD: soft, nontender

PSYCH: mood/affect congruent

MSK: sclerodactyl, mild synovitis in hands, significant stiffness to skin in UE

All labs, studies, and imaging was personally reviewed.

Cr 0.5

K 4.5

**ASSESSMENT and PLAN**

#. Scleroderma

-Clinically with tightened skin around face, eyes, mouth, and hands.

-Labs: ESR, CRP, CPK elevated, ANA, Scl-70 ab positive. RF, acute hep panel, HIV, TSH, CCP, parvo B19, RPR, quantiferon unremarkable. Extended myositis panel and RNA polymerase 3 pending (both are send out labs)

-NIF 12/4 > 40 cmH2O

-urinalysis without proteinuria. Will monitor

-Continue prednisone 5 mg BID, PPI, NSAIDs PRN

-Started cellcept. pt assistance program pending. Pharmacist Yattee Mason is assisting with PA for Myfortic and Cellcept. 404-616-2663. D/w her 12/12 and PA still pending. She will f/u

#. Mod hip osteoarthritis

#. R groin pain - improving - likely multifactorial. per Rheum concern for tendonitis or myositis given his underlying disease process. US unremarkable. Hip XRY with mod osteoarthritis

- cont to monitor, consider MRI if pain persists or worsens. Not currently recc by Rheum. Will defer to Rheum.

- cont steroids/Cellcept

#. Hepatitis B exposure. RUQ US shows hepatic steatosis and intramuscular lipoma

-Serology shows evidence of prior exposure but no signs of active disease.

-continue prophylaxis with tenofovir daily per GI recommendations

-smooth muscle ab negative

#. Iron Deficiency anemia

-Hemoglobin mildly low (11.4) with borderline low ferritin (244)

-Ferritin is likely falsely normalized due to chronic inflammation, and overall represents iron deficiency anemia

-Will start PO iron on discharge

-Follow-up outpatient for colon cancer screening

#. Mild Hypocalcemia

-Monitor for now. Do not want to precipitate further cutaneous calcium deposition

#. Dispo - pt will be returning home. SAR declined to accept him. Will need DME as outlined by PT. Forms signed and placed on the chart. Pt has DME and seems to have received PA (will check c- pharmacy), but pt also has no where to go tonight

Code: Full

Prophylaxis: LMWH

Lines: PIV

Diet: Regular / boost

Contact: Per chart

Disposition: Home

Anish Shah

Emory Team P

PIC 51380

Hospital Medicine Attending

**#Acute on chronic respiratory failure, hypoxemic and hypercarbic  with severe bullous emphysema. Quant gold neg**

- Patient has been declining BIPAP, she has appropriate mentation, declining lactulose. Changed BIPAP to while asleep, hoping for more compliance. Explained to pt risk of respiratory failure and death if she continues to decline BIPAP

- Continue to monitor on step-down

- scheduled duonebs. Wean steroids; imaging showing emphysematous/bullous changes in lungs

- repeat ABG in AM

**#Acute encephalopathy - improved**

- Has several metabolic derangements including hypercapnic, elevated ammonia (likely cirrhosis and with HCV positive, states she has been previously Rx? But cannot comment further)

- CT head shows no acute changes

- Encourage lactulose, cont rifaximin

- Encourage BIPAP pend result of ABG

**#Hypokalemia - improved with repletion**

**#Hypokmagnesium - improved with repletion**

- replete and monitor

**#HTN, borderline controlled**

- Continue Norvasc

**#Non-MI Troponin elevation / BNP elevation**

- Trop now is < .03, BNP down to 217

- Echo shows LV to be normal in size, EF is 65- 70%, there is trace aortic regurgitation and trace pulmonic regurgitation

**#Chronic Thrombocytopenia, likely related to HCV cirrhosis and hypersplenism - plts 50's in 2015. No sign of infection. No sign of bleeding. HIT panel negative**

- monitor closely

- HIT panel negative

- recc outpt Heme referral and treatment of HCV

**#HCV Cirrhosis (per chart, however unable to find confirmatory labs), with thrombocytopenia and suspected encephalopathy**

- Protime and INR are normal 11/29/19 -->repeat coags

- See above re lactulose + rifaximin

- need outpt Hep C referral

**#Vitamin D deficiency / osteoporosis and compression fracture noted on CT**

- Supplementing Vitamin D / calcium

- pain control for compression fracture

**#Drug use disorder**

- Counseling / HH referral

**#Dispo - dc once Home O2 obtained and acid base status stable. Pt may need home BIPAP to be arranged. Difficult to determine given her lack of compliance here.**

**GENERAL:**

- Diet: Regular

- DVT Prophylaxis: Lovenox

- Lines/Catheters currently in place: PIV right arm

- Code Status: Full Michelle W. Sims, MD

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team P**

**Name: Ricky Walker**

**Hospital Day: 22**

Ricky Walker is a 59 y.o. male h/o ESRD, vascular dementia, schizophrenia p/w HTN emergency, hypoglycemia, and volume overload, who has improved with treatment.

**SUBJECTIVE**

NAEO

Doing well this AM

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | hydrALAZINE | 100 mg | Oral | Q8H |
| • | epoetin Alfa-epbx | 4,000 Units | Subcutaneous | Once per day on Tue Thu Sat |
| • | lactulose | 20 g | Oral | Daily |
| • | isosorbide mononitrate CR | 120 mg | Oral | Daily |
| • | NIFEdipine ER/XL | 60 mg | Oral | Daily |
| • | sennosides | 17.2 mg | Oral | BID |
| • | polyethylene glycol | 17 g | Oral | Daily |
| • | cloNIDine | 1 patch | Transdermal | Q7 Days |
| • | normal saline | 10 mL | Intravenous | EVERY 8 HOURS |
| • | aspirin EC | 81 mg | Oral | Daily |
| • | atorvastatin | 40 mg | Oral | Nightly |
| • | carvedilol | 25 mg | Oral | Q12H |
| • | multivitamin | 1 tablet | Oral | Daily |
| • | risperiDONE | 1 mg | Oral | BID |
| • | sevelamer carbonate | 800 mg | Oral | TID w/meals |
| • | torsemide | 40 mg | Oral | Daily |
| • | heparin | 5,000 Units | Subcutaneous | Q12H SCH |
| • | insulin lispro | 0-8 Units | Subcutaneous | TID w/meals |
|  | And | | | |
| • | insulin lispro | 0-4 Units | Subcutaneous | Nightly |
| • | gabapentin | 300 mg | Oral | Nightly |

**OBJECTIVE**

BP 116/65 | Pulse 70 | Temp 36.4 °C (97.6 °F) (Oral) | Resp 18 | Ht 1.702 m (5' 7") | Wt 71.7 kg (158 lb) | SpO2 97% | BMI 24.75 kg/m²

GEN: layign in bed

CV: warm ext, regular rhythm

PULM: easy WOB

ABD: soft, nontender

PSYCH: mood/affect congruent

All labs, studies, and imaging was personally reviewed.

POCT 210

**ASSESSMENT and PLAN**

RICKY WALKER is a 59 y.o. male with PMHx of ESRD, vascular dementia and schizophrenia admitted with hypertensive emergency, hypoglycemia and volume overload. Now stable.

#. Uncontrolled HTN

-Continued home medications: carvedilol 25 BID, hydralazine 100 mg TID

-Continue clonidine to 0.3, Imdur 60 (new meds)

-Now on nifedipine XL 60, holding on dialysis days

-Secondary HTN workup negative, given chronic and ESRD, no indication for Renal US

#. End-stage renal disease on HD

- Cont HD per nephrology schedule, currently on MWF

- Needs outpatient HD center set up, SW/NCM continue to work on assisting with this.

#. Diabetes mellitus, type II

- Long acting insulin stopped given hypoglycemia; had been on 70/30 BID as outpatient

-Sugars labile, currently on POCT + SSI

#. 1/4 Positive blood culture for Staph pettenkoferi

- likely just a contaminant

#. Vascular dementia:

#. Schizophrenia: Has been in and out of nursing homes but unclear where he is currently living.  Needs safe discharge planning

-Continue Risperdal 1 mg twice daily

#. Dispo:

-Per NCM on 12/6, multiple facilities have accepted patient, now waiting confirmation of outpatient dialysis chair

RESOLVED

#. Tn Elevated d/t demand ischemia d/t HTN crisis

Fluids: None Replete lytes PRN.

Diet: Renal

Lines and Catheters: PIV,

VTE Prophylaxis: Heparin

Advanced Directives: Full

Family Contact:  Primary Emergency Contact: Moss,Cynthia, Home Phone: 678-613-1713

Discharge Planning: Medically cleared for discharge. Needs placement and outpatient dialysis set up if can find an accepting facility given history of non-compliance with dialysis

Dispo/Code status. Full Code.

Anish Shah

Emory Team P

PIC 51380

Hospital Medicine Attending

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team P**

**Name: Fidelis Assamo**

**Hospital Day: 4**

Fidelis Assamo is a 84 y.o. male h/o of HFpEF (EF 55-60% on 10/2017 TTE), CKDII, HTN and CVA (2015), TIA (2017) presenting with four day history of progressively worsening BLE with SOB and concern for acute diastolic HF exacerbation. Patient has not required any lasix in almost two years and therefore concern that there is additional underlying issue causing additional stress on heart (ischemic heart disase vs PE) given elevated troponin. Patient admitted to Medicine for additional evaluation and management

**SUBJECTIVE**

NAEO

Well appearing this AM

No complaints

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | furosemide | 40 mg | IV PUSH | Daily |
| • | metoprolol | 12.5 mg | Oral | Q12H SCH |
| • | aspirin EC | 81 mg | Oral | BID |
| • | lisinopril | 5 mg | Oral | Daily |
| • | allopurinol | 100 mg | Oral | Daily |
| • | atorvastatin | 40 mg | Oral | Nightly |
| • | cholecalciferol | 50,000 Units | Oral | Q7 Days |
| • | cyanocobalamin (Vitamin B12) | 1,000 mcg | Oral | Daily |

**OBJECTIVE**

BP 100/64 | Pulse 90 | Temp 37.2 °C (99 °F) (Oral) | Resp 18 | Wt 70 kg (154 lb 5.2 oz) | SpO2 100% | BMI 24.17 kg/m²

GEN: pleasant gentlman, NAD

CV: warm ext, +1 pitting edema of ankles, regular

PULM: easy WOB

ABD: soft, nontender

PSYCH: pleasant, cooperative

All labs, studies, and imaging was personally reviewed.

K 3.6

**ASSESSMENT and PLAN**

#. Acute systolic and diastolic heart failure exacerbation (systolic HF is new diagnosis)

#. BLE edema/Volume overload

#. CKDII

#. Bilateral pleural effusions

#. Moderate cardiomegaly

-BNP 1006

-Repeat TTE with newly reduced EF at 30-35% with moderate global hypokinesis of the left ventricle, diastolic parameters are non-diagnostic with left atrium moderately dilated. Dilated IVC with normal respiratory collapse c/w RA pressure of 8 mmHg

-Starting lisinopril 5 mg daily

-sig12.5 mg metoprolol BID (12/13-p)

-lasix 40 daily, minimal volume overload (12/13-p)

-Fluid restricted diet

-Telemetry

-Repeat BLE US through vascular to assess for DVT

#. Type 2 MI

-Trop trend 0.20--> 0.17--> 0.28-->0.23

-No ischemic changes on EKG, similar to prior EKG from 11/2019, no chest pain

-TTE as above

-BLE US negative for clot, D-dimer elevated at 2581, CTA negative for PE

#. Vitamin D Deficiency

-Continue 50,000 units weekly

#. B12 deficiency

-Continue supplementation

#. HTN

#. H/o CVA and TIAs c/b dysarthria

-Continue ASA and statin

-lisinopril 5 mg and metoprolol 12.5 BID as above

-Amlodipine was stopped during last admission, continue to hold

#. left subcapital femoral neck fracture

-s/p L lip hemiarthroplasty on 11/19/19

-Ortho consulted, recommed 81 mg ASA BID for DVT ppx even while inpatient

-PT/OT consulted for d/c clearance and continued therapy

#. Chronic normocytic anemia

-Continue to monitor

#. Elevated Alkaline phosphatase (improving)

-Continue to trend, likely 2/2 hepatic congestion

Fluids: None

Diet: Pureed, fluid restricted with ensure

Lines and Catheters: PIV

VTE Prophylaxis: Lovenox

Family Contact:  Primary Emergency Contact: Wengi,Susan, Home Phone: 678-551-8901

Discharge Planning: Continues to require inpatient care.

Dispo/Code status. DNR/DNI

Anish Shah

Emory Team P

PIC 51380

Hospital Medicine Attending